STATE PRIMARY CARE GRANTS PROGRAM
FOR MEDICALLY UNDERSERVED POPULATIONS

State Fiscal Year 2008-2009 Application Instructions Checklist

A COMPLETE ORIGINAL APPLICATION must be submitted by **Friday, May 16, 2008**, to the Office of Primary Care and Rural Health.

The Application must be submitted by U.S. Mail or hand delivered ***(faxed copies will NOT be accepted)***:

U.S. Mail Delivery Address:
Office of Primary Care and Rural Health
Utah Department of Health
P.O. Box 142005
Salt Lake City, Utah 84114-2005.

Street Address for Hand Delivery:
Office of Primary Care and Rural Health
Utah Department of Health
288 North 1460 West
Salt Lake City, Utah 84116

Applications that are incomplete, or submitted after the deadline, may be delayed or denied review.

NOTE

✔ Applicants should review the "Definitions Used by the State Primary Care Grants Program." This information is attached to this packet and also listed on our web site at:
http://health.utah.gov/primarycare/pdfs11-00/PrimaryCare/SPCG-Definitions.pdf

✔ Applicants should also review the "Detailed Criteria for Scoring" applications to the State Primary Care Grants Program. This information is attached to this packet and also listed on our web site at:
http://health.utah.gov/primarycare/pdfs11-00/PrimaryCare/SPCG-Scoring.pdf

Funding from the State Primary Care Grants Program **CAN NOT** be used to supplant other existing funding sources. This means that the number of encounters or visits funded by the State Primary Care Grants Program should be over and above the number of encounters or visits covered by other funding sources available to the Applicant Agency.

Primary care services not covered by CHIP, Medicaid, Medicare, PCN, other public health care coverage, or private insurance **MAY** be considered, **IF** the primary care services and costs are clearly detailed and listed in the Application.

ONLY Private Non-Profit Agencies and Public Entities are eligible for funding
(Section 26-17-302(1), UCA).

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CHECKLIST FOR SUBMITTAL

The ***UNBOUND*** original Application must be submitted in the following order:

*Please note: A cover letter is **not** necessary.*

☐ Proposed Project Summary Sheet, completed.

☐ Proposed Project Application *Narrative Questions*, Proposed Project Applications that fail to adequately answer ALL questions will NOT be considered for review. Responses to the Proposed Project Application *Narrative Questions* should be NO MORE than four (4) pages total with one inch margins. The font should NOT be smaller than 10-point. Lines should be double-spaced. Each narrative question must be answered in the order presented. Each page should be numbered and have the name of the Proposed Project and Applicant Agency within the top one inch margin.

☐ Proposed Project Services to be Provided list, completed.

☐ Proposed Project Projections forms, completed.

☐ Proposed Project Sliding Fee Scale used to determine *actual fee to be charged to clients*. Please include a copy of the Sliding Fee Scale that a client can use to determine charges. *If the Proposed Project Applicant does not require their clients to pay a co-payment, please explain why.* **DO NOT INCLUDE ACTUAL LIST OF FEES CHARGED PER PROCEDURE.**

☐ Agency Balance Sheet and Annual Report. Please include a copy of your agency's most recent Audited Annual Report ***(UNBOUND)***, with your one (1) page Balance Sheet ***on top*** of the Audited Annual Report.

☐ Agency Proof of Non-Profit Status. All agencies must supply a copy of proof of non-profit status. Proof of non-profit status can include, but is not limited to, correspondence from the Internal Revenue Service determining your exemption from federal income tax under section 501 (a) of the Internal Revenue Code as an organization described in section 501 (c) (3).

☐ Proposed Project Application Instructions Checklist. Please include this completed Checklist with your **UNBOUND** original Application.

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STATE PRIMARY CARE GRANTS PROGRAM
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State Fiscal Year 2008-2009 Proposed Project Application Narrative Questions

The responses to the items listed below for the Proposed Project Application should be **UNBOUND**, NO MORE than four (4) pages total with one inch margins. The font should NOT be smaller than 10-point. Lines should be double-spaced. The count of the four (4) pages total *does not include* the required forms that must be included with the Proposed Project Application (see Application Instructions Checklist). Each narrative question must be answered in the order presented. Each page should be numbered and have the name of the Proposed Project and the name of the Agency applying for funding. Please be concise and succinct with your responses. Note that the Proposed Project budget narrative (described on the following page) is separate from the Proposed Project Application. Proposed Project Applications that are submitted after the deadline may be delayed or denied review.

Each question must be answered and numbered in the following order:

1. **SUMMARY PARAGRAPH DESCRIBING THE PARENT AGENCY**. Briefly describe the parent agency of the Proposed Project. Paragraph should include: Agency mission, goals, and objectives; how the Agency is managed (county owned, managed by a board or commission, etc.); length of time Agency has been established (been in business); and populations served by Agency. *This section is for Agency information, not Proposed Project information.*

The following questions must be answered for the Proposed Project, not for the parent agency.

2. **PROPOSED PROJECT TARGET POPULATION(S)**: Briefly describe the medically underserved population(s) that the Proposed Project objective(s) will serve **and** include an assessment of need for this population.

3. **PROPOSED PROJECT OBJECTIVES**: Provide specific, measurable objective(s), as well as proposed activities, outcomes, and measures for each Proposed Project objective. Please assure to describe the Proposed Project objectives that you are requesting funding for, **not** the objectives of your entire Agency.

4. **PROPOSED PROJECT EVALUATION/QUALITY REVIEW:** Provide a brief description of the evaluation/quality review program that your Agency will use for the Proposed Project objective(s). Evaluation/quality review programs, may include but are not limited to, the capacity to examine topics such as patient satisfaction and access; quality of clinical care; quality of the work force and work environment; cost and productivity; and health status outcomes.

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State Fiscal Year 2008-2009 Proposed Project Application Narrative Questions

5. **PROPOSED PROJECT INNOVATION:** Provide a description of innovative aspects that your Agency will use to complete the Proposed Project objectives(s). Innovative aspects may include, but are not limited to: creating value out of new or different ideas, new products, new services, or new ways of doing things. These innovative aspects are determined based on whether they are new or different, efficient, and have significant benefit to the community and the underserved populations served by the Proposed Project.

6. **PROPOSED PROJECT COLLABORATION**: Provide information about any existing or future partnerships, collaborative efforts, use of volunteers, or other resources that your Agency will use to complete the Proposed Project objective(s).

7. **PROPOSED PROJECT SUSTAINABILITY OF FUNDING**: Provide a plan of financing for the target population(s), *if State Primary Care Grants Program funding were no longer available*. Also provide evidence of "Other Sources of Funding" for the primary care services provided by your Proposed Project (e.g., funding from the Utah Department of Health, Cardiovascular Program, for blood pressure screening).

8. **PROPOSED PROJECT BUDGET NARRATIVE**: Please provide a brief Proposed Project budget narrative. The Proposed Project budget narrative must explain each Line Item Category of the Proposed Project budget (see the Proposed Project Summary Sheet on the following page). Briefly describe the personnel who will oversee and/or complete Proposed Project activities. Explain other sources of funding included in the Proposed Project budget, such as grants, third party payments (e.g., CHIP, Medicaid, Medicare, PCN,, other public health care coverage, private insurance), donations, etc.

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IDENTIFYING INFORMATION	
Title of Proposed Project: *(Please provide descriptive title)*	
Name of Agency:	
Contact Name ***and*** Title:	
Mailing Address:	
Street Address (if different than mailing address):	
City, State, Zip:	
Telephone:	Fax:
Email Address:	Tax Identification Number:

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STATE PRIMARY CARE GRANTS PROGRAM
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State Fiscal Year 2008-2009 Proposed Project Summary Sheet

Name of Applicant Agency _____

Name of Proposed Project _____

PROPOSED PROJECT SUMMARY INFORMATION Proposed Project budgets should be for the period July 1, 2008 through June 30, 2009		
Dollar Amount for Proposed Project: $		
PROPOSED PROJECT EXPECTS TO SERVE:	Number of Proposed Project Users[2]:_____ The number of medically underserved individuals the State Primary Care Grants Program Proposed Project expects to serve.	Number of Proposed Project Encounters[1]:_____ The aggregate number of encounters that the Proposed Project expects to be providing (**over and above** the Agency baseline encounters).
The Precise Boundaries of the Area to be Served by the Proposed Project [you ***MUST*** specify the City(s) and/or County(ies)]. *Note Answer Required*:		

PROPOSED PROJECT SUMMARY INFORMATION Proposed Project budgets should be for the period July 1, 2008 through June 30, 2009			
Line Item Category	**Column A**	**Column B**	**Column C** **Column A + Column B = Column C**
	Proposed Project Requested Funding	**Other Sources of Project Funding**	**Total Project Funding**
Salary & Fringe Benefits	$	$	$
Travel	$	$	$
Equipment	$ NA	$ NA	$ NA
Supplies	$	$	$
Contractual	$	$	$
Total Costs	$	$	$

[1] "Encounter" means a face-to-face contact between an eligible individual and the awarded Agency's health care provider who exercises independent judgement in the provision of primary care services to the eligible individual and where the services provided under the Proposed Project are rendered and recorded in the eligible individual's record.

[2] "Users" are defined as Eligible Individuals, and means any person, or member of a family, served by the Awarded agency and receives at least one face-to-face encounter.

[3] "Eligible Individual" is defined as is: low income at or below 200 percent of the federal poverty level, or without health insurance including CHIP and Medicaid, or without health insurance that covers primary health care services, or without health insurance that covers a particular primary health care service; has not received primary health care services on an uncompensated basis in the last 24 months; and resides in the State of Utah.

STATE PRIMARY CARE GRANTS PROGRAM
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State Fiscal Year 2008-2009 Proposed Project Services to be Provided

Name of Applicant Agency _____

Name of Proposed Project _____

Proposed Project Services To Be Provided		
In Column A, please check (✓) all corresponding services that the Proposed Project expects to provide to eligible individuals. ***Please note <u>Proposed Project services ONLY</u>, NOT Agency-wide services.***		
SERVICE TYPE		**COLUMN A**
Primary Medical Care Services	General Primary Medical Care	
	Diagnostic Laboratory	
	Diagnostic X-ray	
	Diagnostic Tests/Screens/Analysis	
	Family Planning	
	Following Hospitalized Patients	
	HIV Testing	
	Immunizations	
	Mammography	
	Tuberculosis Therapy	
	Urgent Medical Care	
	24 Hour Coverage	
OB/GYN Care	Gynecologic Care	
	Pap Smear	
	Obstetric Care	
	Prenatal Care	
	Labor and Delivery Professional Care	
	Postpartum Care	
Dental Services	Preventive	
	Restorative	
	Emergency	

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State Fiscal Year 2008-2009 Proposed Project Services to be Provided

Name of Applicant Agency _____

Name of Proposed Project _____

Proposed Project Services To Be Provided		
In Column A, please check (✓) all corresponding services that the Proposed Project expects to provide to eligible individuals. ***Please note <u>Proposed Project services ONLY</u>, NOT Agency-wide services.***		
SERVICE TYPE		**COLUMN A**
Mental Health Services	Mental Health Treatment/Counseling	
	Developmental Screening	
	24 Hour Crisis Intervention/Counseling	
	Other Mental Health Services	
	Substance Abuse Treatment/Counseling	
	Other Substance Abuse Services	
Other Professional Services	Hearing Screening	
	Nutrition Services Other than WIC (Women, Infants, and Children Supplemental Nutrition Program)	
	Occupational/Vocational Therapy	
	Physical Therapy	
	Pharmacy Services	
	Vision Screening	
Enabling Services	Case Management	
	Child Care (during visit to clinic)	
	Discharge Planning	
	Health Education	
	Home Visiting	
	Interpretation/Translation Services	
	Nursing Home and Assisted-Living Placement	
	Outreach	
	Parenting Education	
	Transportation	

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STATE PRIMARY CARE GRANTS PROGRAM
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State Fiscal Year 2008-2009 Proposed Project Projections

Projections for Period: July 1, 2008 thru June 30, 2009

Name of Applicant Agency _____

Name of Proposed Project _____

1. Expected Encounter [1] information, for the period 07/01/2008 through 06/30/2009

BASELINE DATA FOR YOUR AGENCY	PROPOSED PROJECT
Agency-wide data, NOT Proposed Project data	**Expected Proposed Project Encounters [1]**
Total number of encounters [1] *for your Agency's* most recent fiscal year	Total number of Proposed Project patient encounters [1] 07/01/2008 through 06/30/2009

PLEASE USE BEST ESTIMATES (PROJECTIONS) OF USERS EXPECTED TO BE SERVED BY YOUR PROPOSED PROJECT.

2. Expected Proposed Project Users [2] by Age, for the period 07/01/2008 through 06/30/2009

Age Groups	Number of Proposed Project Users [2]
0 - 19	
20 - 64	
65 and over	
Total Proposed Project Users [2]	

3. Expected Proposed Project Users [2] by Income Level, for the period 07/01/2008 through 06/30/2009

Percent of Poverty Level	Number of Proposed Project Users [2]
100% and below	
101 - 200%	
Above 200%	
Unreported/unknown	
Total Proposed Project Users [2]	

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State Fiscal Year 2008-2009 Proposed Project Projections

Projections for Period: July 1, 2008 through June 30, 2009

Name of Applicant Agency _____

Name of Proposed Project _____

4. Expected Total Proposed Project Users [2] by Insurance Status, for the period 07/01/2008 through 06/30/2009

Number of Proposed Project Users [2] Uninsured	Number of Proposed Project Users [2] Underinsured

5. Expected Proposed Project Users [2] by Members of Race/Ethnicity Who Suffer Health Care Disparities *(see "Definitions" of underinsured and uninsured)*, for the period 07/01/2008 through 06/30/2009

Race/Ethnicity	Number of Proposed Project Users [2]
American Indian or Alaska Native	
Black or African American	
Native Hawaiian or Other Pacific Islander	
Hispanic or Latino	
Total Proposed Project Users [2] by Race/Ethnicity	

Total Proposed Project Users [2]	

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